Arizona Ryan White and ADAP Application

I am applying for: ☐ Ryan White Part A ☐ Ryan White Part B ☐ Ryan White Part C ☐ ADAP

Date: _____ **Applicant Signature:**_____

APPLICANT INFORMATION

Last	**First**	**MI**
Birth date (month/day/year)	**AKA (also known by these other names)**	

Gender
☐ Male ☐ Transgender -Male to female
☐ Female ☐ Transgender -Female to male

Ethnicity
☐ Hispanic
☐ Non-Hispanic

Race (choose all that apply)
☐ White ☐ Black or African American ☐ Asian
☐ Native Hawaiian/Other Pacific Islander
☐ American Indian/Alaska Native
☐ Other: _____

Language Preference
☐ English ☐ Spanish ☐ Other
_____

Social Security Number (SSN) or Alien ID if no SSN.*
_____

Primary Phone #
_____
Type: ☐ home ☐ cell ☐ work ☐ other

OK to leave messages? ☐ Yes ☐ No

Secondary Phone #:
_____
Type: ☐ home ☐ cell ☐ work ☐ other

OK to leave messages? ☐ Yes ☐ No

Email Address

Home Address **Apt/Suite #**	**City**	**State**	**Zip Code**	**OK to mail?** Yes ☐ No ☐
Mailing Address (if different) **Apt/Suite #**	**City**	**State**	**Zip Code**	**OK to mail?** Yes ☐ No ☐

Name of Authorized Representative Contact (if any)	**Phone Number**	**Aware of Status?** Yes ☐ No ☐

Ryan White Case Manager Name	**Agency**	**Phone Number**	**Case Manager should be contacted instead of client?** Yes ☐ No ☐

DIAGNOSIS INFORMATION (New Applicants Only)

Date of HIV-positive diagnosis:	**Is this date estimated?** Yes ☐ No ☐	**Have you ever been told you have AIDS?** Yes ☐ No ☐	**Date of AIDS diagnosis:**	**Is this date estimated?** Yes ☐ No ☐

Risk/Exposure Category (answer all questions):
Have you ever had sex with a male? Yes ☐ No ☐
Have you ever had sex with a female? Yes ☐ No ☐
Have you ever used injection (IV) drugs? Yes ☐ No ☐
Have you been diagnosed with hemophilia/coagulation disorder? Yes ☐ No ☐

Have you ever received a blood transfusion? Yes ☐ No ☐
Have you ever received an organ transplant? Yes ☐ No ☐
Did you get HIV from your mother? Yes ☐ No ☐
Unknown Yes ☐ No ☐
Other (please explain):
_____

DIAGNOSIS DOCUMENTATION (New Applicants Only)

New applicants must provide proof of their HIV-positive diagnosis. Please provide one of the documents listed below. Check which one is provided. ***Attach documents to this application.***

☐ Lab report with your full name that shows measurable viral load by bDNA or PCR showing detectable virus level

☐ Un-named ADHS lab result showing HIV-positive diagnosis such as measurable viral load (not undetectable), western blot or IFA. Must also provide the named lab slip with the same number on it.

☐ 1) Positive HIV immunoassay AND positive confirmatory test, OR 2) Positive detectable HIV RNA reflecting the current algorithm approved by the Association of Public Health Laboratories (APHL).

☐ A statement signed by a prescribing medical professional on office letterhead or prescription pad indicating that the individual is HIV positive OR named, electronic health record lab flow sheet demonstrating initial + HIV test OR named, initial HIV immunoassay test. An authenticated lab report, to confirm HIV status must be provided within 60 days.

** SSN information is not used for eligibility determination. It is used to verify income, AHCCCS or verify Medicare coverage.*

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RESIDENCY DOCUMENTS

Please provide **TWO** of the following residency documents issued within the allowable timeframes.

- The documents must include the client's name and home address (no P.O. Boxes).
- **Attach copies to this application.**

RESIDENCY DOCUMENTS (check and attach ONE copy of document)
☐ Any documents from government agency (AHCCCS, Medicare, Social Security, Veteran's Affairs, DES, Food Stamps, Unemployment)- within 60 days
☐ Property tax statement – most recent
☐ Homeowner's association statement - w/in 60 days
☐ Mortgage statement or lease agreement– most recent
☐ Utility or credit card bills (Electric, Water, Gas, Phone, Cable, etc.) – within 30 days
☐ Non-property tax bill or tax assessment statement – most recent
☐ W-2 – most recent
☐ Pay check stubs – in the past 30 days
☐ Bank statement – in the past 30 days
☐ Driver's License or AZ ID Card- issued within one year
☐ AZ vehicle registration – most recent
☐ Tribal enrollment – most recent
☐ US Immigration Identification Card – current
☐ Non-permanent housing letter - current
☐ Primary care provider statement or signed patient demographic page attesting to the specific eligible address – within 30 days
☐ Vehicle insurance card – current
☐ Ryan White Case Manager attestation of home visit or homelessness – dated within 30 days (use the **Attestation** below)
☐ Community Service Agency Residency Attestation of homelessness – dated within 30 days (use the **Attestation** below)

Case Manager Residency Attestation

Agency Use Only: May only be completed by a Case Manager or Part A Eligibility Specialist

_____I affirm I have visited the client at the address identified in the client information section.

_____I affirm the client is homeless.

_____ _____

Staff Member Printed Name | Name of Provider Agency

_____ _____

Staff Member Signature | Date

Community Service Agency Residency Attestation

Agency Use Only: May only be completed by community service agency

_____I affirm the client is homeless.

_____ _____

Representative Printed Name | Name of Provider Agency

_____ _____

Representative Signature | Date

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INCOME AND HOUSEHOLD SIZE

Please provide income documents issued within the allowable timeframes. **Attach copies to this application.**

INCOME SOURCE DOCUMENTS (check all that apply and attach copies)
☐ Annual award letter (Social Security, VA, annual pension, etc.)
☐ Other award letter (TANF, Unemployment, etc.)
☐ 1 month of check stubs or employer statement if no check stub is received
☐ Self-employment records *(1099, Profit and Loss from accounting firm or most recent bank statement)*
☐ Other income source not listed above ***(requires Certification of Income and/or Support)***
☐ No Income ***(requires Certification of Income and/or Support)***

In the table below, list every family member residing within your household (i.e. legal spouse, domestic partner, biological/adopted children)

HOUSEHOLD INFORMATION TABLE

Applicant or Family Member Name	Relationship	Monthly Gross Income if over 18 years old	Source	Over 18 years old?	Claimed on taxes?
Self	Applicant			Yes ☐ No ☐	Yes ☐ No ☐
				Yes ☐ No ☐	Yes ☐ No ☐
				Yes ☐ No ☐	Yes ☐ No ☐
				Yes ☐ No ☐	Yes ☐ No ☐
				Yes ☐ No ☐	Yes ☐ No ☐
				Yes ☐ No ☐	Yes ☐ No ☐
				Yes ☐ No ☐	Yes ☐ No ☐
				Yes ☐ No ☐	Yes ☐ No ☐

EMPLOYMENT STATUS FOR APPLICANT/ADULT IN THE FAMILY UNIT

Check all that apply:

☐ Full-time_____hours per week
☐ Part-time_____hours per week
☐ Seasonal/ temporary
☐ Full or part-time college student
☐ Unemployed
☐ Social Security Disability Insurance (SSDI)
☐ Social Security Income (SSI)
☐ Retired
☐ Self-employed
☐ Other(describe):_____

CERTIFICATE OF INCOME AND/OR SUPPORT

I confirm that I am supporting myself in the following manner (initial and complete all that apply):

_____I, or an adult in my family unit receives money from work performed for which no paycheck stub is received.
The average monthly earnings are: $_____
The occupation is for which these monies are earned is:_____;
_____I am homeless or living in a shelter;
_____I am receiving assistance from another individual. *Please attach a letter of support from this person and describe:*_____
_____I am receiving another source of assistance for obtaining food, water, housing, and clothing.
Please specify the source of the assistance_____.

I attest that to the best of my knowledge and belief that the information submitted is accurate and complete.

_____ _____
Applicant Signature Date

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HEALTH INSURANCE/OTHER PAYER

If you have medical coverage, please attach a copy of your health insurance card and prescription drug card. Please note that you will be required to provide proof of denial for health insurance coverage if it appears you may be eligible.

HEALTH INSURANCE SCREENING

AHCCCS - Arizona Medicaid	**Federal Facilitated Marketplace (FFM) Insurance**
What is your AHCCCS Status? ☐ Enrolled ☐ Pending. Date applied / /____ ☐ Denied ☐ Not eligible. Please explain: _____	**What is your FFM Status?** ☐ Enrolled ☐ Pending. Date applied __/___ /__ ☐ Denied ☐ Not eligible. Please explain: _____

Medicare

Medicare Status : ☐ Enrolled; effective date____/___/_____ ☐ Will be eligible in the next 12 months? date ___/___/ ____ ☐ Not enrolled now but was in the past ☐ Not Applicable **What type of Medicare?** A ☐ B ☐ D ☐ Medicare Advantage Plan	**If you are enrolled in Medicare, what is your Extra help/low-income subsidy (LIS) status:** ☐ Enrolled ☐ Pending. Date applied / /____ ☐ Denied ☐ Not eligible. Please explain: _____

Other Governmental Health Insurance Programs

Are you eligible or receive health services from Veteran's Affairs? ☐ Yes ☐ No	**Are you eligible or receive health services from Indian Health Services?** ☐ Yes ☐ No

Private or Employer-Provided Health Insurance

Can you get insurance through:
☐ My Employer ☐ Spouse, Parent or Domestic Partner ☐ Private, individual plan ☐ COBRA ☐ I cannot get private insurance

Do you have health insurance: ☐ Yes ☐ No
If yes, who do you get the insurance through?
☐ My Employer ☐ Spouse, Parent or Domestic Partner ☐ Private, individual plan ☐ COBRA

Have you applied for coverage? ☐ Yes ☐ No,
If No, when are you eligible to apply for coverage? _____/___/_____

Does your health insurance provide coverage for prescription drugs? ☐ Yes ☐ No

Which of your prescribed HIV medication(s) is NOT covered by the plan? *Please list or attach*:

REFERRAL NEEDS

Have you seen your health practitioner in the past 6 months?	Yes ☐ No ☐
Have you had lab work done in the past 6 months?	Yes ☐ No ☐
Are you taking HIV medications?	Yes ☐ No ☐
Is your housing or living situation stable?	Yes ☐ No ☐
Is your ability to provide your daily living needs stable?	Yes ☐ No ☐
Do you have transportation resources to meet your needs?	Yes ☐ No ☐
Do you have issues with stress and/or depression in your life?	Yes ☐ No ☐
Do you have addictions or substance abuse issues in your life?	Yes ☐ No ☐
Do you want a referral for help with any of the above issues?	Yes ☐ No ☐
Do you have an HIV Case Manager?	Yes ☐ No ☐
Name & Agency:	

Arizona Ryan White and ADAP Application

SUPPORT DOCUMENT GUIDE

REQUIRED SUPPORTING DOCUMENTS – ALL APPLICANTS

- ☐ Proof of Residency – see page 2 for accepted documents
- ☐ Proof of Income – see page 3 for accepted documents
  - ☐ Letter of Support – *if applicable*

    If you signed the Certificate of Income and/or Support, the person helping you must provide a letter of support
- ☐ Proof of Healthcare Coverage (as applicable)
  - ☐ AHCCCS card or approval letter
  - ☐ Medicare card
  - ☐ Private health insurance card
- ☐ AHCCCS Denial – Denial due to failure to submit documentation is unacceptable. Enrollment in Federal Emergency Services (FES) is considered an AHCCCS denial. *If living in Maricopa or Pinal county, applicable denials will be generated through the Central Eligibility Office.*

REQUIRED SUPPORTING DOCUMENTS – New Applicants Only

- ☐ Proof of Diagnosis – see page 1 for acceptable documents

REQUIRED SUPPORTING DOCUMENTS – ADAP/RWPB Only

- ☐ Medicare Extra Help/LIS Award or Denial Letter
- ☐ If you are enrolled in the FFM and receive premium assistance from ADAP attach a copy of your most recent federal taxes beginning April 16, 2015
- ☐ MAGI worksheet, if applicable
- ☐ If you have private insurance, please provide copies of your health insurance
  - ☐ Premium information
  - ☐ Formulary (list of medications)
  - ☐ Benefits Summary
- ☐ Page 7 of the application completed and signed by your medical provider

Arizona Ryan White and ADAP Application

RYAN WHITE PART A ONLY

Please initial each statement and sign below:

_____ I may qualify for Ryan White funded services even if I have other insurance.

_____ I will report any changes to my household income, my address, and other things that may affect my services. If I do not, I may not be eligible or may have to re-pay the Ryan White Program.

_____ At least every six months, I will complete the required eligibility process. If I fail to provide documents, I will not remain in the program.

_____ The information provided in this application is true and accurate to the best of my knowledge. Any unreported items may result in loss of eligibility.

RYAN WHITE PART A RELEASE OF INFORMATION

I, _____ (*Client Name)*, authorize Care Directions, Arizona School of Dentistry and Oral Health, Chicanos Por La Causa, Maricopa County Employee Benefits and Health, Ebony House, Maricopa Integrated Health System, Maricopa County Office of Health Education & Promotion, Phoenix Indian Medical Center, Southwest Center for HIV/AIDS and Sun Life, Ryan White HIV/AIDS Program Grantees and/or Contractors, to disclose my protected health information (PHI) and other information from my records to any Ryan White HIV/AIDS Program (Ryan White) Grantee or Contractor operating in Maricopa County and/or Pinal County, Arizona.

The purpose of the disclosure is to permit Ryan White HIV/AIDS Program Grantees and/or Contractors to exchange my PHI or other information from my records to Ryan White Contractors and Grantees for the purposes of:

- Continuity of care, treatment, payment, and health care operations, including eligibility, demographic. emergency treatment, payments to Contractors or other statistical reporting information;
- Mandated reporting, including client-level data reporting;
- Disclosures required by law;
- Legal process and proceedings;
- Oversight including quality assurance reviews and audits of Ryan White-funded services provided;
- Disclosure to a Medical Examiner;
- Disclosure of notifiable public health conditions; and
- Inclusion in shared data systems for demographic, eligibility, and other statistical reporting;
- If in the course of providing services to a client, a RWPA provider identifies information that could be harmful to the client or the public; the provider may report that information to the appropriate authorities.

If required for the purposes listed above, I authorize the disclosure of the following information for the period of time from the date of my signature to one (1) year from the date of my signature:

- HIV/AIDS and other communicable disease information, including HIV Counseling and Testing;
- Behavioral, Mental Health or Psychiatric treatment information; and/or
- Substance abuse treatment information.

Unless I revoke this authorization earlier, it will expire one (1) year from the date of my signature. I also understand that my revocation will not apply to information that has already been released in response to this Release. To revoke this authorization, I must submit a written request to

Central Eligibility Office, Care Directions
1366 E. Thomas Road, Suite 203
Phoenix, AZ 85014

By signing this Release of Information, I release all Ryan White Grantees and Contractors, their employees, officers, directors, medical staff, and agents from any legal responsibility or liability for the disclosure of information to the extent indicated and authorized in this Release. I also understand that Ryan White Grantees and Contractors will maintain the confidentiality of my disclosed PHI or other information, and that they will use my PHI or other information only for the purposes listed above.

I understand the matters discussed on this Release of Information and that by signing below, I acknowledge that I have received a copy of the Ryan White Program Notice of Privacy Practices, Central Eligibility Provider List, Client Rights/Responsibilities, and Client Grievance Policy.

_____	_____	_____
Printed Name	Signature	Date
_____	_____	
Signature of Legal Representative	Relationship to Client	

Arizona Ryan White and ADAP Application

ADAP/Ryan White Part B ONLY

MEDICAL PROVIDER PAGE (MPP) - must be completed by Prescribing Medical Care Provider

Applicant Name	**Applicant Birth Date**		
Medical Provider Name	**License Number**		
Medical Provider Address **Apt/Suite #**	**City**	**State**	**Zip Code**
Medical Provider Phone: (_____) _____	**Medical Provider Fax:** (_____) _____		

TESTS

Test Name	**Result**	**Date of Test**
CD4 CELL COUNT (required within the last 6 months)		
VIRAL LOAD (within the last 6 months)		

MEDICATION(S) PRESCRIBED

PLEASE list full prescription below with a copy of prescriptions OR attach a copy of the eRX:

Drug	Strength	Quantity	Instructions	# Refills

I certify that this applicant has been diagnosed as having HIV infection.

I understand that I am required to notify the vendor pharmacy within 7 calendar days of the following:
- Prescribing a new medication
- Discontinuing a medication

I agree to notify the Arizona ADAP/Ryan White programs within 14 calendar days following my notification of:
- Death of the patient/client
- Change in the HIV Medical Provider

I certify that to the best of my knowledge and belief all information, I have provided is accurate and complete.

If the client is going to go without medications for longer than 90 days, please contact ADAP at 602-364-3610 OR 1-(800) 334-1540.

_____ _____

Signature of Medical Provider Date

Please return to: ADAP, Arizona Dept. of Health Services 150 N. 18th Avenue, Suite 110 Phoenix, AZ 85007-3233
Fax: 1-(602) 364-3263
Phone: Toll-Free 1-(800) 334-1540

Arizona Ryan White and ADAP Application

ADAP/Ryan White Part B ONLY

ADAP/RWPB RELEASE OF INFORMATION

Arizona Department of Health Services – AIDS Drug Assistance Program (ADAP) Application (Under Provision of A.A.C. R9-6-401, et seq)

I agree that I or my designated representative must provide AZ ADAP with proof of ineligibility for enrollment for Arizona Health Care Cost Containment System (AHCCCS) and/or for Medicare Part D low-income subsidy, if not provided with this application. I also agree that I or my designated representative must provide AZ ADAP with proof of enrollment in a Medicare drug plan, if I am eligible for Medicare. Last, I agree that I or my designated representative must provide AZ ADAP with proof of or exception from enrollment the Federally Facilitated Marketplace, if applicable.

I grant permission to AZ ADAP to share the minimum necessary information contained in this application with AHCCCS, for the purpose of determining AHCCCS eligibility, with Medicare and the Social Security Administration for the purpose of determining eligibility for a low-income subsidy and enrollment in a Medicare drug plan, with my primary care provider or their designee to confirm clinical information and acquire test results related to the service I am requesting, with the vendor pharmacy to assist with drug distribution, with other Ryan White providers in Arizona with whom I am enrolled to maintain my enrollment in ADAP or ADAP-Assist, and with any other entity as necessary to establish eligibility for enrollment in AZ ADAP, to maintain continuity of care, treatment, payment and health care operations.

I or my designated representative agrees to notify the AZ ADAP of any changes that affect my eligibility within **30** calendar days. Such changes include: any change in MAGI-based income, household size, residential or mailing address, phone number, employment status, availability of insurance coverage, AHCCCS eligibility, or primary care provider.

I understand that my AZ ADAP eligibility will terminate if I do not refill my AZ ADAP-covered Anti-Retroviral (ARV) medications for greater than 90 days.

I certify that to the best of my knowledge and belief, I am eligible for AZ ADAP and all statements made herein regarding personal and other non-medical information are accurate and complete. I certify that I am not eligible for any health insurance plan that would provide the support for which I am applying, other than those which I have declared.

I understand that my failure to be accurate and complete may prevent or delay a determination of eligibility to receive assistance from AZ ADAP, or may result in termination of my enrollment.

I understand that copies of the rules and policies for support documents are available upon request through the AZ ADAP Office.

I understand that if there is any discrepancy in the documents provided to AZ ADAP, I must present government issued documentation to confirm my identity.

I understand that AZ ADAP may terminate my enrollment in AZ ADAP if I exhibit violent or threatening behavior to a representative of the AZ ADAP or the AZ ADAP pharmacy.

I understand that AZ ADAP ceases to provide drugs when available funding is exhausted or terminated. AZ ADAP is not an entitlement program and does not create a right to assistance absent available funding (R9-6-402).

I,_____(applicant's printed name) authorize Lisa Fuentes, Jimmy Borders, Claudia Cardiel, Jessica Alvidrez, Louisa Vela, Greg Romero, LisaMarie Bates, Laura Kroger, Rhonda Garcia, or John Lick, in their capacity as staff members of the AIDS Drug Assistance Program (ADAP) of the Arizona Department of Health Services, to represent me for the following purposes:

1. During my ADAP enrollment, facilitating the payment of premiums for marketplace coverage by the ADAP, provided that the ADAP determines that the marketplace coverage remains the most cost effective means to provide me with HIV medications for which I am seeking assistance from the ADAP. Please note that the Advance Premium Tax Credit (APTC) must be applied to total premium cost prior to ADAP facilitating the payment of premiums for marketplace coverage.
2. I further authorize the staff members named above, in their capacity as staff members of the ADAP of the Arizona Department of Health Services, to disclose my confidential information to the extent necessary to carry out the three purposes listed above.

I understand and agree that this authorization will remain in effect for a period of one year from the date of signature.

Applicant Name (PRINT) Signature Date

Return this application to: ADAP, Arizona Dept. of Health Services
150 N. 18th Avenue, Suite 110, Phoenix, AZ 85007-3233
Fax: (602) 364-3263
v.05012014

ADAP/Ryan White Part B ONLY

MAGI WORKSHEET FOR APPLICANTS WITHOUT TAXES

Arizona Department of Health Services

Mock MAGI Worksheet

Only for use with applicant's who have not filed a tax return for the most recent tax year

Income types listed in ALL CAPS are not calculated in MAGI, but are required fields

For any income losses, enter negative $ amount

Client Name **SS#** – – **DOB** / /

Income Sources Total Monthly $ Amount for all Legal Household Members				
Wages, Salaries, tips, etc.		Pensions & Annuities (Veteran/Employer Based Pensions, Retirements,or Disability)		
Taxable Interest				
Tax Exempt Interest		Rental real estate,partnerships, S Corporations, Trusts, ect.		
Ordinary Dividends		Farm income or loss		
Taxable refunds of State/Local Income Taxes		Unemployment Income		
Alimony or other Spoussal Support Received		Retirement Income from Social Security (SSA)		
Business Income/Loss		Disability Income from Social Security (SSDI)		
Capital Gain/Loss		SUPPLEMENTAL INCOME FROM SOCIAL SECURITY (SSI)	Specialty Line A	
Other Gains/Losses		Other income (Jury Duty Pay, Gambling Winnings)		
IRA Distributions - Taxable amount		CHILD SUPPORT RECEIVED, WORKERS COMP, MONETARY GIFTS	Specialty Line B	
Total Column 1		**Total Column 2**		
Total Income (Total Column #1 plus Total Column #2)				

Non MAGI (Not calculated but, required) Total Monthly $ Amount for all Legal Household Members			
Educator Expenses		Penalty on Early Withrawal of Savings	
Business Expenses		Alimony Paid	
Health Savings Account		IRA deduction	
Moving Expenses		Student Loan Interest Deduction	
Deductible Part of Self Employment Tax		Tuition and Fees	
Self Employed SEP, SIMPLE plans		Domestic Production Activities	
Self Employed Health Insurance Deduction			
Total Column 1		**Total Column 2**	
Total Adjustments (Total Column #1 plus Total Column #2)			
Add Specialty Line A			
Add Specialty Line B			
(Total Adjustments+ Spec Line A+Spec Line B) **= NON MAGI SUBTOTAL**			
		Total Income minus Non MAGI Subtotal above	
Modified Adjusted Gross Income (MAGI)			

Notes

Client Signature Date

(Signature, Date and Supporting Documentation is also required)

Revised 7/15/13

V.10012013 -11-

Arizona Ryan White and ADAP Application

ADAP/Ryan White Part B ONLY

MAGI INSTRUCTIONS

Eligibility Criteria for Medicaid and Insurance Affordability Programs: Modified Adjusted Gross Income (MAGI)[4]

	Income	Assets	Household size	Residency	Immigration status	Redetermination
MAGI	*Criteria* Based on Internal Revenue Service definition of income[1] MINUS: • Educator expenses • Business expenses • Health savings account deduction • Moving expenses • Certain self-employment expenses • Penalty on early withdrawal of savings • Alimony Medicaid-specific exceptions to MAGI definition of income: • Amount received as lump sum is only counted as income in month received • Educational grants are excepted from income • Certain American Indian/ Alaska Native income is excepted[2] • Across-the-board 5% disregard of income (all other income disregards eliminated) Budget periods: • MAGI income determinations are based on "point-in-time" income for Medicaid • Income determination for premium tax credits are based on projected annual income (credits are paid in advance and reconciled at end of year based on tax returns) • States have option of using point-in-time or projected annual income methods for *current* Medicaid beneficiaries and to take into account reasonably predictable income changes for new and current beneficiaries	*Criteria* No assets test	*Criteria* Tax filing unit (individual plus anyone for whom individual claims personal exemption) For individuals who do not file a tax return and are not claimed as tax dependent, household size is the individual and the following (if living with the individual): • Spouse • Natural, adopted, and step children (those under age 19, or, at state option those under age 21 and full-time student) • If applicant is a child, natural, adopted, and step parents and natural, adopted, and step siblings[3]	*Criteria* State of residence is the state where the individual is living and Intends to reside, including without a fixed address; or state in which person has entered with a job commitment or seeking employment (whether or not currently employed).	*Criteria* Undocumented immigrants are barred from coverage through exchanges or Medicaid Legal immigrants are barred from Medicaid coverage for 5 years, but are eligible for subsidized coverage through exchanges during this time.	*Criteria* Once every 12 months.
	Supporting documents The final regulation limits use of documentation and requires states to use electronic sources for verification wherever possible, including: • Internal Revenue Service (IRS) • State Wage Information Collection Agency • Social Security Administration (SSA); and • Other social services programs (e.g., SNAP) The regulation requires states to access information available through the federal "Data Services Hub" as well as the Public Assistance Reporting Information System (PARIS). If information obtained through electronic sources is not "reasonably compatible" with information provided by applicant, agency must request additional documentation.	*Supporting documents* N/A	*Supporting documents* Self-attestation accepted	*Supporting documents* Self-attestation accepted	*Supporting documents* Social Security Number or paper documentation (verification with federal data hub required)	*Supporting documents* States are required to use an administrative renewal process using electronic data sources. If eligibility cannot be verified with existing databases, beneficiaries must be sent a pre-populated renewal form and must supply missing information.

[1] IRS Form 1040 defines income as: wages, salaries, tips, interest, dividends, taxable refunds, credits or offsets of state and local income taxes, business income, capital gain, IRA distributions, pensions and annuities, rental real estate, royalties, partnerships, S corporations, trusts, unemployment compensation, and farm income.
[2] Exceptions include: distributions from Alaska Native corporations and settlement trusts, distributions from any property held in trust located within prior federal Indian reservation, distributions and payments from property rights associated with federal Indian reservation land, and student financial assistance under the BIA.
[3] Certain exceptions to MAGI household size rules apply, including the provision that married couples living together are each included in the other's household regardless of filing status. For a full list of exceptions (most of which involve treatment of children), see State Health Reform Assistance Network: Overview of Final Medicaid Eligibility Regulation (April 2012).
[4] MAGI applies to income determinations for newly-eligible Medicaid beneficiaries (the 2014 expansion population), some traditional Medicaid groups (children, parents, and caretakers), and subsidies to purchase insurance through exchanges. MAGI does NOT apply to certain traditional Medicaid groups (e.g., disabled populations and medically needy). Application of MAGI for new applicants will begin January 1, 2014. For current Medicaid beneficiaries, the MAGI formula will be effective on March 31, 2014 (or the next regularly scheduled renewal if later).

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